Participatory Practices: Learning From Experience*

PN-ABZ-557

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CROSSING SECTORS AND HIERARCHICAL LEVELS FOR COMMUNITY-BASED ENVIRONMENTAL HEALTH

Increased Productivity Through Better Health Project(IPTBH) Experience from Belize [1]

The Development Problem

In January 1989, an evaluation of the Increased Productivity Through Better Health Project (IPTBH) concluded that although USAID and the Government of Belize achieved their numerical targets (number of latrines built, houses sprayed, health education messages delivered), villagers didn't use the facilities or services provided and the disease burden continued to increase.

The evaluation found that the project measured results in terms of outputs constructed, rather than customer participation or training in infrastructure use and management. Therefore, the project had failed so far to build an institutional foundation, sense of ownership, or lasting impact.

As the last year of the project approached, USAID contracted with the Water and Sanitation for Health (WASH) and the Vector Biology and Control (VBC) project for assistance in planning interventions and creating an institutional strengthening program.

USAID PARTICIPATORY PRACTICES: LEARNING FROM EXPERIENCE is a series studies of participatory approaches in USAID programs. They are intended to help staff consider similar approaches and share experiences. USAID's Participation Forum and GP-NET, an electronic conversation group, enable development practitioners worldwide to discuss problems and successes in the use of participation. For further information please E-mail Diane La Voy (DLAVOY@USAID.GOV) or Wendy Kapustin (WKAPUSTIN@USAID.GOV).

Wendy Kapustin drafted the following summary after extensive consultation with May Yacoob, EHP project, and a thorough review of available project documentation.

The Participatory Practice: Bringing Together Government Service Providers Across Sectors and Hierarchal Levels

Joint visits to communities

USAID technical teams with Belizean Government counterparts gathered community-level data and identified the principal obstacles to implementing the management capability at the community level. Three problems were identified: the vertical nature of community health programs (separate programs for each disease), lack of cross-sector collaboration, lack of community support, poor management, and lack of trained staff.

Ministry of Health staff and staff of ministries responsible for infrastructure installations (water systems construction, sanitation, drainage, etc.) spent approximately three weeks in villages researching issues and problems within the community.

They found that villagers were not using latrines because these were literally swarming with mosquitoes; villagers were washing clothes with piped water while they drank rainwater because they preferred its taste; there was excessive lead in drinking water because villagers painted their catchment tanks on a regular basis with oil-based paint containing lead; and that villagers generally attributed chills and fevers to changes in the seasons, not to malaria.

Meetings of policy makers, mid-level, and district level staff

USAID sponsored a series of meetings. USAID presented to the Belizean policy-makers--permanent secretaries under the Minister of Health--the benefits of establishing multidisciplinary teams for implementing community-based skills that would address behavioral changes and village-level management.

By the first meeting's conclusion, policy makers pledged to support the creation and collaboration of multidisciplinary, intersectoral teams. Within the Ministry of Health, intersectoral programs included malaria spraying, health education, primary health care, maternal child health services, water quality testing, and latrine inspection.

The second USAID-sponsored policy meeting involved, in addition to the policy makers, mid-level managers (directors of health education, primary health care, vector control, water supply and sanitation, etc.), and field-level staff. The Belizeans designed their own agenda and USAID participated as consultants. Starting from the premise that villagers were not using facilities or services provided, the purpose of this meeting was to reach agreement on the best course of action to address this problem.

This two-day meeting was the first time that field-level government workers and policy-makers collaborated to define and propose solutions to problems. Mid-level and field (district-level) staff and the technical staff for each sector at the central level presented findings on local health behavior from data that they had gathered directly from communities.

For example, vector control evaluators attended to cases of malaria, sprayers visited the community and, in parallel fashion, health educators dealt with the problems of latrines and potable water systems. The technical staff for the various sectors had not consulted one another and had missed the opportunity to benefit from each other's experience and skills. To address these problems, USAID urged that health and sanitation services be provided by multidisciplinary teams consisting of individuals working on environmental health, health behavior, and water and sanitation. USAID also urged that there be increased communication and cooperation among traditionally vertical programs.

Training the field and ministry-level teams*

In 1993, USAID sponsored a total of five workshops--a project start-up workshop and four training-of-trainers (TOT) workshops--for the district level health teams. Each workshop lasted no more than a week and was subsequently followed by on-site visits. This reinforced new skills and allowed for additional support as needed.

The project start-up workshop was designed to help all parties reach a common understanding of the background, scope of work, and purpose of the project. Besides the district level health teams, start-up workshop participants included key staff of the government implementing agencies and the project officers from the various donor agencies.

USAID provided four separate TOT workshops of up to five days to 20 to 30 persons from the multidisciplinary teams at the district level. The course was based on practical work-related tasks in community development and empowerment, and covered needs assessments, verbal and nonverbal communication skills; the use of open-ended and probing questions; techniques for planning, facilitating, and leading group discussions; problem-solving; and conflict resolution. The facilitators modeled the behavior the participants were to use in the communities.

Participants were gradually trained in methods to identify high-risk behaviors and local resources with which they could help communities address problems, and in ways to communicate sensitively with community members. When a problem arose, participants raised issues at the following workshop and after group discussion and the introduction of problem-solving techniques, they proposed solutions. This led to a process of continual learning.

Results of teamwork and crossing hierarchical levels*

Mid-level officials from the Ministry of Health with extensive input from the communities then drafted a policy paper. This paper established clear objectives, procedures, responsibilities, and policies for community health programs. In 1996, three years after the end of the project, the Government of Belize was continuing a community health program approach based on teamwork at the local level and organized committee meetings between policy makers and field-level workers.

The meetings between technical staff and policy makers continued. Budgetary allocations for the various programs continued to be based on the plans that the district teams provided--which had emanated from discussions with the village teams.

An example of how this teamwork greatly improved the efficiency of community health programs was the response to an outbreak of cholera. When the Government of Belize identified two cases of cholera in a district, the district teams mobilized immediately and delivered services and mobilized resources. By comparison, before the USAID-supported institutional strengthening began, a different district had five confirmed cholera cases. The different programs had not been able to coordinate to provide the required support. As a result, the five cases became 250 cases before public authorities took action more than six months later.

Discussion Points

1) By traveling together throughout the countryside, the various health providers in charge of implementing activities in health care, water quality, vector control, and health education at the district level all learned the value of each other's work. This increased cooperation and interaction led to their greater efficiency and acceptance in the community.

2) Establishing village environmental health committees that addressed issues causing ill health related to water and infrastructure was an important way to decentralize the health care system. These committees helped to empower individuals, health workers, and communities to understand and exercise control over decisions that related to their health and well-being.

3) Mid-level program managers' involvement in promoting, supporting, and sustaining the use of interdisciplinary teams at the district level was critical to their success.

4) For community health committees to hold their own in this relationship, it was essential that they be formed by those who would be affected by them.

5) Local participation in service delivery programs builds a constituency for policy change.

Resources

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